IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0036
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CERTIFIED MAIL: 7003 0500 0003 1966 9968

September 10, 2008

T. Shane Bell, Administrator
Nampa Care Center
404 North Horton Street
Nampa, ID 83651

Provider #: 135019

Dear Mr. Bell:

On **August 28, 2008**, a Recertification and State Licensure survey was conducted at Nampa Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 23, 2008**. Failure to submit an acceptable PoC by **September 23, 2008**, may result in the imposition of civil monetary

penalties by **October 13, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **October 2, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 2, 2008**. A change in the seriousness of the deficiencies on **October 2, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 2, 2008** includes the following:

Denial of payment for new admissions effective **November 28, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 28, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 28, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **September 23, 2008**. If your request for informal dispute resolution is received after **September 23, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135019	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA CARE CENTER	**404 NORTH HORTON STREET NAMPA, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 281	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, it was determined the facility failed to ensure professional standards were followed regarding the administration of medications. This was true for 1 of 14 sampled residents (# 1). Findings include:

Resident #1 was admitted to the facility on 6/28/08 with diagnoses including cerebral vascular accident, pneumonia, schizophrenia, dementia, hepatitis C, and malnutrition.

Resident #1's August MAR documented Transdermal Nicotine Patch, originally ordered 7/31/08 for 14 mg (milligram) for two weeks, then 7 mg for two weeks, then discontinue.

During a medication pass on 08/26/08 at approximately 9:00 am, a LN realized she did not administer a transdermal patch to the resident. She signed Resident #1's MAR for a 7 mg transdermal patch, entered the resident's room, picked up the patch in an enclosed packet that she had previously dropped on to the floor, and administered the medication.

On 4/16/97, informational letter #97-3 was sent to all long term care providers. The letter stated, "...the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication. We have held three meetings with the [Executive Director] of the Board of Nursing, to ensure that there is no confusion regarding the Board's position. The [Executive Director] confirmed that the Board's expectation, and the accepted standard of practice, is that licensed nursed document those things they have done, not what they intend to do. Upon checking with Idaho nursing education programs, it was confirmed that the schools continue to instruct students to document what they have done, seen, or heard, after these events occur."

On 08/27/08 at approximately 3:00 pm, the DON, Administrator, and the RN Consultant acknowledged the above observation.

This is a repeat citation from the 6/15/07 recertification survey.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135019	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAMPA CARE CENTER	404 NORTH HORTON STREET NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: David Scott, RN, Team Coordinator Lea Stoltz, QMRP Kari Davies, RD, LD, MPH Amanda Bain, RN Janice Ryan, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Nampa Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED SEP 23 2008 FACILITY STANDARDS	
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to maintain or enhance residents' dignity and respect by knocking on residents' rooms prior to entering, expressing indifference when a resident was attempting to communicate his needs, and during	F 241	**F 241** **Resident Specific** The IDT (inter-disciplinary team) reviewed resident #1's communication board and process for staff interaction. The LN (licensed nurse) interacted with resident #'s 22, 23, & 24 regarding the invasion of privacy with lack of knocking on the door. Resident #'s 18, 19, & 20 are monitored for dignified assistance with meals. Staff is re-educated for consistent resident interactions with dignity.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	EXECUTIVE DIRECTOR	091908

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 mealtimes. This was true for 2 of 14 sampled residents (# 's 1 and 19) and five random residents (# 's 18, 20, 22, 23, and 24). Findings include: 1. Resident #1 was admitted to the facility on 6/28/08 with diagnoses including cerebral vascular accident, pneumonia, schizophrenia, dementia, hepatitis C, and malnutrition. Resident #1's most recent MDS assessment, a change in condition, dated 8/6/08, documented the resident used a communication board and gestures as modes of expression. At approximately 8:55 am on 08/26/08, Resident #1 was pointing to his communication tablet attempting to converse with LN #2. The LN had completed the administration of the resident 's Jevity and medications via his feeding tube. The resident was spelling on his tablet, and the LN stated, " D " " O " " C ", and then stated, "I don't know what you are saying." She proceeded to clean up the resident's bedside table, and dropped the resident 's enclosed transdermal patch on the floor. The LN did not notice the medication had fallen to the floor. The resident was again pointing to his communication tablet, trying to converse with the LN. The resident was spelling on his tablet, and the LN stated, "Doctor," and then stated, "wants." The resident continued to use his communication board to try and converse with the LN. She continued to tidy up the resident 's room, expressing indifference as the resident tried to communicate his needs. The LN exited the room. She returned to the resident's room, and administered his transdermal patch that had fallen on to the floor. The LN provided no further	F 241	**Other Residents** The IDT reviewed other residents for dignity concerns with interventions provided as indicated. **Facility Systems** Staff is educated and supervised to implement care with dignity, including but not limited to, knocking before entering resident rooms, giving undivided attention to a resident using a communication device, and assistance with meals. Staff re-education is provided with monitoring for ongoing implementation. **Monitor** The DNS (director of nursing sevices) and/or designee will monitor staff interactions with patients during rounds. Any concerns will be addressed immediately. The PI (Performance Improvement) committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 241	Continued From page 2 communication or assistance to the resident. 2. During the medication pass on 08/26/08 at 7:10 am, LN #1 entered resident #23 's and #24 's room without knocking, identifying herself, or requesting permission to enter. After the surveyor knocked and requested permission to enter, the LN stated she had just been in the residents' room prior to the administration of the medications. 3. On 08/26/08 at 7:40 am during the medication pass, LN #2 entered resident #22 's room without knocking, identifying herself, or requesting permission to enter. On 08/27/08, at approximately 3:00 pm, the DON, Administrator, and the Nurse Consultant acknowledged the above observations. 4. On 8/26/08, at 7:58 a.m. and at 8:01 a.m., the surveyor observed a Nurse's Aide (NA #1) use Random Resident #19's clothing protector to wipe orange juice from the resident's face during the breakfast meal in the facility's Rose Garden dining room. At 8:15 a.m., the surveyor observed NA #1 use Random Resident #20's clothing protector to wipe food from the resident's mouth during the breakfast meal in the facility's Rose Garden dining room. 5. On 8/26/08, at 8:30 a.m., the surveyor observed Random Resident #18 sitting alone in the Rose Garden dining room with cooked cereal running out the left corner of his mouth, down his chin and onto his clothing protector. No other residents or staff were in the dining room at the	F 241		

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F 241	Continued From page 3 time of this observation. Resident dignity and respect was not maintained or enhanced by using clothing protectors rather than napkins to wipe food and fluids from the residents' mouth in a crowded dining room during breakfast, nor when a resident was left unattended with cooked cereal dripping from his mouth and chin in the assisted dining room. NOTE: This is a repeat citation from the annual recertification survey of 6/15/07.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide services in a timely manner that accommodated individual resident needs. This was true for two random residents (#s 18 and 21) requiring staff assistance for eating and toileting. Findings include: 1. On 8/26/08, at 6:32 a.m., surveyors observed the hallway call light activate above Random Resident #21's room in the 400 Hall. Surveyors observed the activated light over the resident's hallway door and at the nurse's station, where the auditory alarm was also sounding. From inside	F 246	**F 246** **Resident Specific** The IDT reviewed the need for timely meal presentation and call light response for resident #'s 18 & 21. Staff is re-educated for timely provision of services. **Other Residents** The IDT reviewed other residents for timely response to needs. **Facility Systems** Staff is educated for timely provision of care to include but not limited to, timeliness of answering call lights and the breakfast procedure for pulling tray cards as each resident enters the dining room. Re-education was provided related to call light response and hush-no-rush breakfast tray delivery system. **Monitor** The LN supervisor and/or designee assigned to the dining room will perform random checks of meal cards during breakfast to	

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F 246	Continued From page 4 the room, the surveyor could hear Random Resident #21 calling out repeatedly, "Help me, please. God, help me. Oh, help me, help me." At the nurse's station, approximately 10 paces from the resident's room, surveyors observed an LN performing paperwork. The hallway and nurse's station light were within view of the LN, and the alarm and resident could be heard. At 6:38 a.m., a housekeeping staff member pushing a delivery cart of clean linen walked down the hall and delivered clean laundry to the nearby clean linen closet. The staff member then pushed her cart past the resident's room and nurse's desk, where the LN was arranging medications on a portable cart, and turned the corner into the facility's 500 Hall. The call light above the resident's hallway door and at the nurse's station were still within view of the LN at the portable medication cart, the alarm was sounding, and the resident's pleas for assistance could still be heard. At 6:40 a.m., surveyors observed the facility's Staff Development Coordinator (SDC), walk down the hall, enter the resident's room and close the door to within inches of shutting completely. Through the slightly open door, the surveyor asked the SDC whether Random Resident #21 needed toileting assistance. The SDC responded in the affirmative, exited the room, and walked to the nurse's station, where she asked an NA walking through the 500 Hall to assist Random Resident #21 in the 400 hall. At 6:42 a.m., the NA entered the resident's room and deactivated the call light. At 6:55 a.m., the surveyor interviewed the SDC. The SDC stated she was assisting residents on	F 246	identify that cards have been pulled for residents whom have arrived in the dining room. At the end of the meal the LN supervisor will validate meal cards for each resident in the dining room. The DNS and/or designee will observe call light response times twice weekly. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 246	Continued From page 5 the 400 and 500 halls because an NA had "forgot" to provide a ride to the facility for another NA, who had been called in. When the surveyor asked why an LN within view of the hallway light and nurse's station light, and within hearing distance of the alarm and Random Resident #21's pleas for assistance had failed to respond to the resident, the SDC stated, "Well, you can train them, but ..." 2. On 8/26/08, at 7:35 a.m., surveyors observed breakfast trays being delivered to residents in the Rose Garden dining room. NAs were assisting those residents who required feeding assistance. At 8:10 a.m., when most residents present at 7:35 a.m. had finished their meals and departed the dining room, surveyors observed two NAs assisting one resident with breakfast. Four other residents were in the dining room, including one male resident who had not yet received a breakfast tray, although the resident was observed with the other residents at 7:35 a.m. The surveyor approached the two NAs and asked whether Random Resident #18 was supposed to have breakfast. The two NAs expressed surprise that the resident had not received a meal and NA #1 stated, "Oh, let me go see if they ordered a tray." NA #1 then exited the Rose Garden dining room. At 8:14 a.m., 39 minutes after the resident was first observed, NA #1 returned to the Rose Garden dining room with a breakfast tray, which she placed on the table in front of Random Resident #18 and set up for the resident to eat independently. NA #1 then returned to the resident she had been assisting prior to leaving the dining room.	F 246		

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F 246	Continued From page 6 At 8:22 a.m., the facility's Dietary Manager (DM) was interviewed. The DM, when asked why Random Resident #18 did not receive a tray until a surveyor brought it to the attention of staff, stated that NAs are required to "pull menu tabs" and deliver those tabs to the kitchen as residents awake and arrive at the dining room during the "Hush No Rush" breakfast meal.	F 246		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, including soiled microwaves in 2 of 3 med rooms, periwash pump dispensers in 8 resident rooms in the 100 hall, and a soiled sink in the 400 hall med room. This had the potential to affect all residents in the 100, 300 and 400 halls. Findings include: On 8/27/08, at 9:50 a.m., while conducting a general tour of the facility, the following was observed: * The microwave used to warm patient foods in the 300 hall medication room area was spattered with food on all interior surfaces, including the top and side walls of the microwave. * The microwave used to warm resident foods in the 400 hall medication room was spattered with	F 253	**F 253** **Resident Specific** Periwash pump dispensers have been removed from the walls for rooms 104,106, 108, 110, 111, 116, 119, & 120. Microwaves and sinks with hard water buildup have been cleaned. **Other Residents** The ED (executive director) and maintenance director rounded to identify any other rooms with periwash pump dispensers, soiled microwaves, and sinks with hard water deposits. These areas have been cleaned and dispensers removed. **Facility System** Staff is educated on proper housekeeping cleaning and schedules/process, to include but not limited to, the cleaning of microwaves and sinks. The ED makes rounds with the maintenance director and/or housekeeping supervisor weekly to provide a safe/sanitary environment. Re-education was provided related to cleaning of microwaves and sinks with hard water deposits.	

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F 253	Continued From page 7 food on all interior walls. * The sink in the medication room in the 400 hall was stained with built-up lime scale and dirt. During an interview with the LN on the 300 hall, the nurse acknowledged that the microwave was dirty. During an interview with the LN on the 400 hall, the nurse acknowledged the microwave and sink were dirty. Periwash pump dispensers in resident bathrooms in rooms 108, 110, 111, and 120 did not have bottles of periwash attached to them. Pumps in rooms 104, 106, 116 and 119 had bottles attached which were empty or very low on contents. During an interview with the housekeeper on 8/26/08 at 10:40 a.m., she stated that the facility no longer used the periwash pumps but used a different product. During an interview with the maintenance director on 8/26/08 at 11:00 a.m., he stated that the dispenser pumps had been scheduled for removal, but this had been halted pending clarification of objections to their removal by staff.	F 253	**Monitor** Housekeeping supervisor will validate daily cleaning schedules and randomly review microwaves and sinks for cleanliness. The PI committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate. **Date of compliance** October 2, 2008	
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	**F 278** **Resident Specific** The IDT reviewed resident #'s 1 &12 MDS assessments for accuracy in coding of pain. Inaccuracies were addressed.	

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F 278	Continued From page 8 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that a resident's MDS assessment was accurate in coding for pain for 2 of 14 (#12 and 1) sampled residents reviewed for MDS accuracy. Findings include: 1. Resident #12 was admitted to the facility on 12/8/05, and readmitted on 6/21/05, with diagnoses of left leg injury, inability to bear weight, and a history of dementia. The 8/12/08 quarterly MDS documented the patient experienced mild pain less than daily. Resident #12's Pain Assessments of 5/13/08 and 8/12/08 documented pain levels as verbalized	F 278	**Other Residents** The ID team reviewed other residents' MDS coding for pain. No further inaccuracies were identified. **Facility Systems** Staff is educated and competency tested for MDS coding, to include but not limited to pain. Re-education for MDS accuracy is provided with peer review for accuracy monthly. **Monitor** The DNS and/or designee will review one resident weekly for accurate coding of the MDS, to include but not limited to, residents pain level. The PI committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 278	Continued From page 9 between 5 to 8 using a 0 to 10 pain rating scale with zero indicating no pain and increasing incrementally to 10 which indicates worst pain. The Medication Record (MAR) for 6/2008 documented pain ratings of 3 to 8, the MAR for 7/2008 documented pain ratings of 3 to 5 and the MAR for 8/2008 documented pain ratings of 4 to 8. The 8/08 recapitulation Physician's Orders stated the resident was to receive Norco 5/325 1 tablet each morning and Norco 10/325 1 tablet each evening for pain. An order was also in place for Norco 5/325 1 tablet every 6 hours to be given as needed for pain. The August 2008 Medication Record also documented the times the prn Norco was administered: Once on 8/1 through 8/7/08; 8/9, 8/11, 8/13, 8/15, 8/18 and 8/20 through 8/26. Twice on 8/8 and 8/16/08; The MDS Nurse Coordinator was interviewed on 8/27/08 at 2:10 p.m. and acknowledged the resident had experienced greater than mild pain during the during the assessment period. 2. Resident #1 was admitted to the facility on 6/28/08 with diagnoses including cerebral vascular accident, pneumonia, schizophrenia, dementia, hepatitis C, and malnutrition. A Pain Assessment form, dated 6/30/08, rated the resident's pain level as a 7 out of 10 (1 indicating very mild pain and 10 indicating very severe pain) with the conclusion, "Pain management intervention is necessary."	F 278		

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F 278	Continued From page 10 Resident #1's most recent significant change MDS assessment, dated 8/6/08, documented that the resident experienced mild pain less than daily. Resident #1's Medication Record was reviewed for August 2008. Pain rating score documentation showed the resident had pain levels between 2 and 6 (with an average level of 5 indicating moderate pain) daily. The August 2008 Medication Record also documented the times the prn Roxanol was administered: Once on 8/1 and 8/17/08; Twice on 8/3, 8/14, 8/18 and 8/19/08; Three times on 8/2, 5, 9, 10, 12, 13 and 22/08; Four times on 8/4, 6, and 23/08; Five times on 8/7, 15, 16, 21, and 25/08; Six times on 8/8 and 24/08; and seven times on 8/20/08. The DON and MDS Nurse Coordinator were interviewed on 8/27/08 at 8:20 AM. The DON stated that although the resident reported daily pain at an average level of 5 for the month of August 2008, and received prn pain medication up to seven times daily, the resident did not always display non-verbal signs of pain. No other information was offered as to why the MDS had been coded to reflect only mild pain less then daily.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	**F 280** **Resident Specific** The IDT reviewed resident #10's care plan for clarity. Revisions were made as indicated.	

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F 280	Continued From page 11 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not revise care plans related to approaches for skin integrity for 1 of 14 sample residents (#10). Findings include: Resident #10 was admitted to the facility on 4/3/04 and readmitted on 11/16/06 with diagnoses of cerebral vascular accident, dementia, hypotension and status post gastrostomy. Resident #10's 8/1/08 quarterly MDS stated maximum staff assist was required for all areas of ADLs, the resident received all fluids and nutrition via G tube (gastrostomy feeding tube) and the resident was incontinent of bladder and bowel. The Comprehensive Care Plan, dated 11/16/06 and updated 8/7/08, identified a problem for	F 280	**Other Residents** The IDT reviewed other resident care plans related to clearly reflecting family desires for the resident. The IDT will review resident care plans in detail in conjunction with the quarterly assessment and/or change of condition assessment. Residents will be reviewed over the next quarter. **Facility Systems** Residents/responsible parties are encouraged and given opportunity to provide input to resident care routines. These individualized interventions are placed on the care plan throughout the resident stay. LN's will receive re-education regarding the need for clarity when reflecting interventions and family desires on the plan of care. **Monitor** The DNS and /or Designee will review at least one plan of care each week to monitor for clarity. Any concerns will be addressed immediately and discussed with the IDT and PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 280	Continued From page 12 compromised skin integrity due to immobility, incontinence, decreased sensation and history of pressure ulcers. The first approach to address the skin integrity problem was, "Attends [adult incontinent briefs] worn for skin protection and dignity. Check and change routinely. Keep open to air with pad on bed when PT [patient] in bed, except during food/fluid intake may have Attends." Resident #10's recapitulation Physician Orders for 8/08 stated the resident was to receive tube feedings via pump over a 16 hour period daily. In addition, water flushes were ordered for 4 times daily, leaving relatively few times a day when the resident was not receiving food/fluids. The DON and RN consultant were interviewed on the care plan approach on 8/26/08 at 10:00 a.m. They confirmed the approach was not clear, and that the family suggestions for when the Attends were worn had been integrated into the approach without clarity. The care plan instructions for the use of incontinent briefs was not clearly written to instruct staff on their use. This is a repeat citation from the 6/15/07 recertification survey.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**F 309** **Resident Specific** The IDT reviewed resident #'s 1 & 12 regimen for pain control. Physicians were contacted and plan of care adjusted to meet resident needs.	

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide residents with sufficient care and services to adequately control pain. This was true for 2 of 17 sampled residents (#s 1 and 12). Findings include 1. Resident #1 was admitted to the facility on 6/28/08 with diagnoses including cerebral vascular accident, pneumonia, schizophrenia, dementia, hepatitis C, and malnutrition. Resident #1's care plan, with original problem date of 6/28/08, listed "Comfort altered, pain R/T [related to] generalized pain." The listed interventions were: *"Administer pain medications per physician's orders and monitor for effectiveness", *"Non-pharmocological (sic) interventions for pain relief: heat, cold, massage, positioning, music, relaxation, imagery, diversion, etc", *"Position for comfort", *"Assess effectiveness of pain medication and report to physician if not effective", *"Conduct routine pain assessment." A Pain Assessment form, dated 6/30/08, rated the resident's pain level as a 7 out of 10 (1 indicating very mild pain and 10 indicating very severe pain) with the conclusion, "Pain management intervention is necessary, refer to resident plan of care."	F 309	**Other Residents** The LN management team reviewed other residents' receiving PRN pain medication. Physicians were contacted and plan of care adjustments made as indicated. **Facility Systems** Residents are assessed for pain on admission, quarterly, and with change of condition. A pain scale is validated each shift. Scheduled/routine pain medications are provided as indicated. Break through pain is reassessed with physician notification and plan of care adjustments. Re-education was provided for pain management. **Monitor** The DNS and /or designee will review two residents pain medication regimen weekly. Any concerns will be addressed immediately. The PI committee will discuss as indicated and may adjust the frequency of the monitoring as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 309	Continued From page 14 The Physician's Orders for Resident #1 listed Roxanol (morphine sulfate), originally ordered on 7/9/08, for "20 mg/ml Q 2 HRS PRN for pain [20 milligrams per milileter every 2 hours as needed for pain]." Resident #1's Medication Record was reviewed for July 2008. Pain rating scores were ordered to be documented at the start of each shift. 25 of the 30 days in July had a pain rating between 2 and 7 (with an average level of 5 indicating moderate pain). The July 2008 Medication Record also documented the times Roxanol was administered: Once on 7/9, 10, 24, 25 and 30; Twice on 7/19, 20, 26, and 28; Three times on 7/21, and 27; Four times on 7/22; Five times on 7/23; and Six times on 7/29. A Resident Progress Note, dated 8/1/08, stated, "Res[ident] still c/o [complains of] neck pain, gave prn Roxanol." An entry on 8/3/08 stated, "Still appears to be having increase in pain." A note on 8/19/08 stated, "Freq[uent] use of prn Roxanol for general c/o pain. Request sent to MD to evaluate regime ? [question] if he needs Roxanol D/T [due to] change of condition." Resident #1's most recent significant change MDS assessment, dated 8/6/08, documented that the resident experienced mild pain less than daily. A handwritten note dated 8/10/08, on the original pain assessment form, stated, "Using prn Roxanol for general c/o [complaints of pain].	F 309		

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F 309	Continued From page 15 Requested MD to evaluate current regime D/T Roxanol originally used D/T poor condition." A Monthly Behavior Summary form, with an undated hand-written note, stated, "Nrsg [nursing] reports increased health c/o with concerns with med[ication] seeking with Roxanol. Will request MD to evaluate upon next rounds." Resident #1's Medication Record was reviewed for August 2008. Pain rating score documentation showed the resident had pain levels between 2 and 6 (with an average level of 5) daily. The August 2008 Medication Record also documented the times the prn Roxanol was administered: Once on 8/1 and 8/17/08; Twice on 8/3, 8/14, 8/18 and 8/19/08; Three times on 8/2, 5, 9, 10, 12, 13 and 22/08; Four times on 8/4, 6, and 23/08; Five times on 8/7, 15, 16, 21, and 25/08; Six times on 8/8 and 24/08; and seven times on 8/20/08. Neither the July nor August 2008 Medication Records had any documentation to indicate non-pharmacological interventions for pain control were utilized. The DON and MDS Nurse Coordinator were interviewed on 8/27/08 at 8:20 AM. The MDS Coordinator stated the reason for the prn pain schedule was because the resident, although non-verbal, was able to communicate via a communication board when he was experiencing pain. The resident would point to a number, 1 through 10, to indicate how severe the pain level was. The surveyor showed the MDS Coordinator	F 309		

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F 309	Continued From page 16 and DON the July and August 2008 Medication Records, which documented that the resident was requesting pain medications multiple times on most days. When questioned why a scheduled pain regimen had not been considered for this resident to prevent pain, the DON stated that the resident had a history of drug seeking behavior. She also stated that although the resident indicated he had pain, he did not appear to have any symptoms of pain. A resident with average pain scores of 5 on most days during July and August 2008, had only prn pain medication ordered. The resident received pain medication up to seven times daily to manage pain. The most recent MDS assessment coded the resident as experiencing only mild pain less than daily. The facility identified a history of drug seeking behavior as one reason for the prn schedule although continuing this schedule may have had the potential to reinforce that behavior as the resident was given medication whenever requested. Facility staff did not inform the Physician of the potential need to re-evaluate the pain medication schedule until 8/10/08. As of the survey on 8/26/08, the Physician had not re-assessed the resident's need for a routine pain medication regimen. In addition, no documented evidence could be found to indicate staff ever utilized non-pharmacological interventions in managing the resident's pain. 2. Resident #12 was admitted to the facility on 6/21/05, and readmitted on 12/8/05, with diagnoses of left leg injury, inability to bear weight, and history of dementia. The 8/12/08 MDS documented the patient	F 309		

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F 309	Continued From page 17 experienced mild pain less than daily. Resident #12's care plan, with original problem date of 5/24/07, listed, "Comfort altered, pain R/T [related to] chronic back pain R/T joint discomfort R/T LE [lower extremity] pain R/T increased pain eve/noc HRS [evening/night hours]." The 8/21/07 goal listed, "Pain will be between 1-3 as exhibited by no painful expression, no expression of pain or discomfort with movement." The interventions were: *"Administer pain medications per physician's orders and monitor for effectiveness" *"Non-pharmocological (sic) interventions for pain relief: heat, cold, massage, positioning, music, relaxation, imagery, diversion, etc" *"Report complaints and early signs of pain to licensed nurse" *"Assess characteristics of pain (Location, duration, quality, aggravating/alleviating factors, radiation, intensity) & Doc (document)" *"Assess effectiveness of pain medication and report to physician if not effective" *"Conduct routine pain assessment. Eval(uate) 'irritability' with pain issues" *"Implement measures to relieve pain (i.e.: lift, turn, massage, distract, postion [position])" The Physician's Orders for Resident #12 ordered on 5/14/08, for Norco 5/325 mg [milligrams] 1 Tablet PO [orally] am and pm for generalized pain, and ordered on 6/25/07 Norco 5/325 mg 1/2-1 Tablet PO Q 6 HRS PRN [orally every six hours as needed]. A Physician's Order dated 10/19/06 ordered Neurontin 300 mg TID [3 times daily] for leg pain. The Physician's Orders prescribed on 7/24/08 Cymbalta 60 mg PO [orally] QHS [daily at bed time].	F 309		

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F 309	Continued From page 18 A Pain Assessment form, dated 5/13/08, rated the resident's pain level as 5 to 8 on a 0 to 10 scale with the conclusion, "Pain management intervention is necessary, refer to resident plan of care." A handwritten note, dated 5/13/08, stated, "Requested MD [physician] to review eve/noc [evening/night] pain regime d/t [due to] periodic break thru pain with long hx [history] noc [night] time flare-ups." A handwritten note, dated 8/12/08, stated "Cymbalta added for depression [and] enhancement of pain meds, cont. [continue] use of prn. Requested MD to review on rounds." Review of the Medication Record (MAR) for 6/08 documented pain ratings of 3 to 8 with pain ratings of 5 or above 21 days out of 30. According to the 6/08 MAR, Resident #12 complained of pain levels of 4 to 5 on 6/1-2, 10-11, 18, 27, and 29-30, but there was no documentation of PRN Norco given or nonpharmacologic interventions implemented. Of 22 doses of prn Norco given, only 12 doses were documented for effectiveness during June 2008. The MAR for 7/2008 documented pain ratings of 0 to 5 with a level of 5 documented 21 times out of 31. According to the 7/2008 MAR, Resident #12 experienced a pain level of 5 for most of the month and was given Norco 24 evenings of 31. Eighteen of those 24 doses were documented as evaluated for effectiveness. The 8/2008 MAR documented pain rating of 5 on 8/10, 8/12, 8/17, and 8/19, but Resident #12 did not receive Norco for pain. Only 17 of 22 prn doses of Norco were evaluated for effectiveness; Cymbalta 60 mg was documented as given every morning. There was no documentation of	F 309		

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F 309	Continued From page 19 effectiveness for pain medication enhancement or side effects regarding the Cymbalta. Neither the July nor August 2008 Medication Records had any documentation that indicated non-pharmacological interventions for pain control were utilized. During an 8/27/07 interview with the MDS Coordinator at 8:25 am, she acknowledged the resident had experienced moderate to severe pain during the months of June, July and August and that the doctor had not been contacted between 5/13/08 and 8/12/08 with reports of the resident's responses to pain medication interventions. The facility failed to provide adequate care and services to prevent a resident from continuing to injure herself through non-pharmacological interventions, including distraction, individual activities, and increased supervision. The facility also failed to provide adequate pain relief management for two residents who experienced mild to severe pain on a daily basis.	F 309		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide meal assistance as care planned in order to maintain the resident's ability to feed herself and maintain weight. This was the case for 1 of	F 311	**F 311** **Resident Specific** The IDT reviewed resident #6's dietary plan. Staff is re-educated to follow the resident plan of care for dining/meal assistance and alternate meal options. **Other Residents** The LN management team reviewed other residents for meal plan implementation with interventions provided as indicated.	

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F 311	Continued From page 20 14 sampled residents (#6). The findings include: Resident #6 was admitted to the facility on 3/18/05 with diagnoses of urosepsis, confusion, congestive heart failure, history of anemia with B12 and iron deficiency, hypertension, hypothyroidism, osteoarthritis, and peptic ulcer disease. The resident's 7/28/08 quarterly MDS stated moderate impairment in cognitive skills for daily decision making was present, and the resident required supervision and set up assistance for eating. Resident #6's 3/18/08 Comprehensive Care Plan, updated 7/31/08, identified a problem with nutritional alteration related to weight loss and medical diagnoses. Listed approaches included "Allow time to feed self. Supervise with prompting and verbal cueing. Assist as needed to complete task." On 8/26/08 at 7:40 am, Resident #6 was observed continuously in the Rose Garden dining room during the breakfast meal. She was set up for the meal at 7:55 am. Resident #6 took infrequent bites of food, waiting several minutes between. Staff verbally prompted the resident to eat at 8:05 am, asking if the resident liked the food. No other prompts, cues, or assistance were observed during the remainder of the meal. The resident ate approximately 1/2 of the food and 3/4 of the beverages. No alternative foods were observed to be offered. On 8/26/08 Resident #6 was observed in the Rose Garden dining room from 11:55 am to 12:45 pm. Staff did not prompt, verbally cue or	F 311	**Facility Systems** Resident plan of care is communicated to staff for implementation. Dining room seating is determined based upon level of assistance required. Staff is educated for meal assistance, to include but not limited to, cueing, physical assistance, and alternate food options. Re-education was provided for meal assistance. **Monitor** The DNS and/or designee will review dietary plan of care implementation during meal service rounds. Any concerns will be addressed. The PI committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 311	Continued From page 21 otherwise offer to assist the resident during the entire meal. Resident #6 promptly ate all of the puree fruit, most of the milk and 1/2 a slice of bread, then stopped. After several minutes the resident picked up a spiced apple ring with her fork, then put it down. During the 50 minute observation, the resident sat without eating or drinking for most of the meal after the initial few minutes. Resident #6 ate approximately 1/4 of the potatoes, 1/3 of the meat, none of the carrots, 1/2 slice of bread and all the puree fruit. At 12:45 pm staff wheeled her from the table. No alternate foods were offered to the resident. Meal monitor flowsheets for 8/26/08 documented that the resident ate only 50% of breakfast, 75% of lunch and 25% of dinner that day. Meal monitor flow sheets for July and August 2008 documented the resident rarely ate more than 50% of her meal. During an interview on 8/26/08 at 11:25 am, the dietician acknowledged the facility had noted a decrease in Resident #6's weight and intake. The resident had not experienced a significant weight loss, but was to be monitored for poor intake.	F 311		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F 323** **Resident Specific** The IDT reviewed resident # 4 related to risk for falls and injury. The mat was replaced at the bedside during survey as indicated. Staff is re-educated for consistent replacing of bedside mats for safety. Resident #9 was reassessed with updates to individualize care plan interventions for an increase of individualized activities and increased supervision at peak self-injury	

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F 323	Continued From page 22 Based on observation, staff interview, and record review, it was determined the facility failed to implement care planned interventions to prevent falls for residents at risk for falls or provide sufficient supervision to protect residents against self-injury. This was true for 2 of 17 sampled residents (#4 and 9) and had the potential to cause harm. Findings include: 1. Resident #9 was admitted to the facility on 4/6/05 with diagnoses of diabetes mellitus, renal insufficiency, Alzheimer's disease, constipation, renal and uterus disease, deep vein thrombosis of a lower extremity, edema, iron deficient anemia, pain, hypothyroidism, and history of colon cancer. The resident's most recent quarterly MDS assessment, dated 8/14/08, documented the following: * Moderately impaired cognitive skills for daily decision making * Short- and long-term memory impairment * Mental function varied over the course of a day * Repetitive physical movements * Use of anti-psychotics Resident #9's Care Plan, dated 8/15/08, identified the following Problem, Goal, and Approach with corresponding dates of Care Plan inclusion: * "Problem: Pressure ulcers/skin/stasis ulcer potential: r/t [related to] DM [diabetes mellitus], r/t use of ASA [aspirin], r/t mixed incontinence, r/t LE [lower extremity] edema, r/t neurodermatitis, r/t chronic picking [at] fingers/cuticles, r/t H/O [history of] finger tip amputation." - 4/7/05 * "Goal: No serious harm to self from picking." - 8/14/08 * "Approach: Picks off any dressign (sic) that are	F 323	times of day. Staff is educated to care plan updates. **Other Residents** The IDT reviewed other residents for accident prevention, to include but not limited to, replacing of bedside mats and increased supervision for consistent implementation. Staff re-education was provided as indicated. **Facility Systems** Residents are assessed upon admission, with changes in condition and/or fall, and at least quarterly related to accident prevention. A plan of care is developed and modified as indicated, to include but not limited to increased supervision, safety devices, and behavioral intervention to prevent self-injury. DNS, LN management team, and direct care staff peer monitor for consistent implementation. Staff re-education is provided regarding accident prevention and the need for consistent implementation of supervision, safety devices, and individualized interventions. **Monitor** The DNS and/or designee will review on rounds fall risk interventions consistently implemented at the bedside. Additionally, will review two charts weekly to validate increased supervision and non-pharmacological interventions for behaviors/self-injury are implemented timely and consistently. Any concerns will be addressed immediately and discussed with the ID team as indicated. The PI committee will discuss as indicated and may	

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F 323	Continued From page 23 applied to fingers. Referred to surgeon for possible fiberglass casting. Frequent reminders by staff to not pick [at] fingers. Moistutizing (sic) to hands [and] cuticles QD [daily]." - 8/14/08 Resident Weekly Skin Check Sheet(s) (WSCS), Nurse's Notes (NN), Physician Telephone Orders (PTO), and Condition Change Forms (CCF) for Resident #9 documented the following for February and March 2008: * 2/21/08 - NN "Physician on rounds, labs discussed, discussed [Resident #9] constantly picking skin off her fingers. N/O [New orders] received for F/U [follow-up] lab." * 3/4/08 - WSCS "[No] new skin issues except for [right] middle finger [illegible] from 1st knuckle to end of finger area is dry and cracked resident picked at it [illegible] the cracked areas open." * 3/19/08 - CCF "Res[ident] c/o [complains of] pain r/t [related to] middle finger on [right] hand. Res[ident] has bandage on finger and refuses to take off for nsg [nursing] staff to assess. She is requesting MD [physician] to look [at] site. Upon rounds 3/20/08 please assess and advise Nsg staff of new tx [treatment] orders or would you like to send pt [patient] to dermatologist?" * 3/25/08 - WSCS "No skin issues except for [right] middle finger cracking [and] peeling." * Undated - CCF "Resident's middle finger very red swollen	F 323	adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 323	Continued From page 24 redness back hand up top wrist has a 5 cm [centimeter] lump near top of wrist. Resident c/o pain going up arm area warm [right] hand." * 3/28/08 - PTO "Send resident to [local hospital emergency room] for eval[uation] of middle finger [right] hand. Redness swollen." * 3/30/08 - NN "Family here [and] took resident for [follow-up] trip to [local hospital emergency room and] returned. Finger cont[inued] swollen [and] tender. Abx [Antibiotic] given as per order [without] side effects." * 3/31/08 - NN "Cont[inue] to c/o lots of pain. Daughter called [and] will pick her up this p.m. [evening] to take her FU [follow-up] to [local hospital emergency room]." A radiology report from the local hospital, dated 3/28/08, documented the following, "Opinion: Possible occult trauma to the distal end of the tuft of the right third digit. Superimposed osteomyelitis is not excluded." An Operative Report from the local hospital, dated 3/31/08, documented that Resident #9's right middle finger was amputated at the most distal joint. The report documented, "Infected right middle finger with osteomyelitis." Resident Weekly Skin Check Sheet(s) (WSCS), Nurse's Notes (NN), Physician Telephone Orders (PTO), and Condition Change Forms (CCF) for Resident #9 documented the following for April 2008:	F 323		

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F 323	Continued From page 25 * 4/17/08 - WSCS "[Right] finger middle stitches are intact. [No] s/s infection. Resident keep[s] picking at bandage. No other skin issues." * 4/22/08 - WSCS " [Right] hand middle finger cont[inues with] stitches intact. [Resident #9] keeps picking at incision [and] it is becoming reddened. [No] other skin issues are noted." * 4/27/08 - CCF "Resident's [right] middle finger is healed. Suture line closed. [No] s/s infection. May we DC [discontinue] the bandage? She is constantly picking it off." Resident Weekly Skin Check Sheets (WSCS), Nurse's Notes (NN), Physician Telephone Orders (PTO), and Condition Change Forms (CCF) for Resident #9 documented the following for May and June 2008: * 5/15/08 - NN "Had tip of [right] middle finger amputated. No longer [with dressing changes], but cont [with] scabs along tip of finger [at] incision site. Resident frequently picks [at] site d/t [due to] poor judgment. No s/s of infection. No open skin issues." * 6/5/08 - WSCS "[No] skin issues except [right and left] middle fingers where she has been picking at them. [No] s/s infection." * 6/8/08 - CCF "Resident is picking at her [right] middle finger to	F 323		

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F 323	Continued From page 26 the point she is getting sores on it. No redness or drainage, but d/t her picking it does bleed at times. Surgery site has healed. On her [left] middle finger at the cuticle line to first knuckle she has picked at that so much that it is raw and drips blood at times. It is also red. We have bandaged it numerous times, but she picks the dressing off." * 6/12/08 - CCF "Resident has continually picked [at left] middle finger causing cuticles to bleed [and] putting herself [at] risk for infection. Picks off any dressings. Order for splint, which has been ordered. Dx [Diagnosis] Dementia [with] poor judgment. Seems to have OCD [Obsessive Compulsive Disorder] s/s. Could you please assess on rounds [and] make any recommendations." * 6/13/08 - WSCS "[Resident #9] does keep picking [at bilateral] middle fingers. [Right] one has become infected. To begin abx 6/14." * 6/18/08 - NN "Resident cont[inues] to pick at both middle fingers [left] finger from cuticle to first knuckle is red, raw looking from resident continues picking at it." * 6/20/08 "[No] skin issues except for [left and right] middle fingers. They are red [and] very raw from resident picking at them. At this time have a finger brace on." * 6/20/08 - CCF "Currently on abx tx [antibiotic treatment] for [left] middle finger. Cont[inues] to pick [at] cuticle [and]	F 323		

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F 323	Continued From page 27 surrounding tissue. Resident cont[inues to] picks off any attempts [at] protective dressings. Dx Dementia [with] poor judgment." * 6/25/08 - Nursing Communication to Physician "Surgeon refused to follow. Along with any treatment to finger will you consider antipsychotic for OCD or 'Picks Disease?' If yes, can [local psychiatric services facility] then follow monthly?" A Physician's Progress Note, dated 6/25/08, documented the resident had an appointment with the physician that day for "open sores on fingers." The physician documented, "She is here because she continues to pick at her fingers. She will not stop. Tip of right 3rd finger already had to be amputated. She is not picking at the right fingers and there already has been infection. It is healing, but she continues to pick at it and is at high risk for same problem occurring on the left fingers." The Progress Note included a diagnosis of "Neurodermatitis" and ordered "Risperdal tablet, 0.25 mg [milligrams]" daily for 30 days. * 6/26/08 - WSCS "Cont[inues] to wear [bilateral] finger braces to each middle finger to stop her from itching." * 6/26/08 - NN "Resident refuses to wear splints fingers [illegible] angry looking when she continues to pick at them." * Undated - NN "Becoming very adjatated (sic) [and] anxious about people checking her fingers. Cont[inues] picking [at right] middle finger until she has scabs around it. Now is picking [at left] middle finger around fingernail until she has it all red [and]	F 323		

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F 323	Continued From page 28 bleeding. Have tried dressing it [and] she picks bandage off." * 6/30/08 - NN "Noted this pm to have been picking [at] both middle fingers and cuticles [and] skin fold areas. She says she is not doing any picking - will cont[inue] to monitor." * 6/30/08 - NN "Noted that she is now picking [at] index finger on [right] hand besides both middle fingers. Area around cuticles are red [and] bleeding. Says she is picking off dead skin." A Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review written in July for June 2008 documented, "Res[ident] picks at self to point of harming self to point of infection. Picks at nails, cuticle, [and] any open sore, scabs [and] bandages. Risperdal was started in June [and] increased in July [with] minimal effect. Order received to have [local psychiatric services facility] to follow." The GDR documented that the resident's Risperdal was increased to 0.5 mg daily for neurodermatitis on 7/7/08. Resident Weekly Skin Check Sheets (WSCS), Nurse's Notes (NN), Physician Telephone Orders (PTO), and Condition Change Forms (CCF) for Resident #9 documented the following for July 2008: * 7/2/08 - NN "Resident came up and asked for a bandaid. Noticed she had [left] hand in a fist and [right] hand covering it. When looked at hand she had about a teaspoon of blood in palm of [left] hand and [left] middle finger was dripping blood. She	F 323		

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F 323	Continued From page 29 had picked the entire cuticle area from base of fingernail and up both sides of finger. Finger cleaned, 2 X 2 [2-inch square dressing] put on and a splint [illegible] area taped. Resident denied picking at finger, states she does not know what happened." * 7/7/08 - PTO "[Change] Risperdal to 0.5 mg PO QHS [by mouth daily at bedtime]." * 7/8/08 - WSCS "Occas[sionally] cont[inues] to pick [at] middle fingers. Some dry picked at skin on [left] middle finger. [Right] middle finger looks good." * 7/15/08 - WSCS "Resident fingers have all scabbed and open areas from her picking at them." * 7/23/08 - CCF "Resident receiving Risperdal for neurodermatitis. Significant picking [at] skin [at] cuticle site, causing sores [and] infection. Sl[ight] improvement noted of skin picking. [Physician] here for rounds 7/17/08 [with] no [changes and] to cont[inue] to monitor for now." * 7/31/08 - WSCS "Finger on left hand nail bed has a pie shaped piece missing, almost a perfect piece shape. Has several scabbed areas present." * 7/31/08 - PTO "[Local psychiatric care facility] NP [nurse practitioner] to follow r/t neurodermatitis [with] continued skin picking." A Monthly Behavior Summary/Psychoactive	F 323		

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F 323	Continued From page 30 Gradual Dose Reduction (GDR) Review for Resident #9 for July 2008 and written in August 2008 documented, "Res[ident] conts [continues] to pick at fingers to point of self -injury. Referred ... for fiberglass cast." Resident Weekly Skin Check Sheets (WSCS) Nurse's Notes (NN), Physician Telephone Orders (PTO), and Condition Change Forms (CCF) for Resident #9 documented the following for August 2008: * 8/10/08 - NN "[Left] finger middle where resident has picked off a little more than half of the fingernail. Clean, dry, [no] s/s infection, no bleeding noted. Will put dressing or bandage on. She is now starting to pick at her first finger [left] nail still intact. Refuses to leave bandage on and will 'sneak' around picking at it." * 8/11/08 - NN "[Physician] faxed back and stated to make appt [appointment] with [surgeon] for a possible fibercasting." * 8/14/08 - NN "Res[ident] cont[inues] pick [at] fingers [and] scabs. Nrsg [Nursing] notes decline in picking. Currently receives Risperdal [with] effective results. Resident has a hx [history] of amputation of tip of finger. Has chronically picked [at] skin [and] cuticles on hands. Resident [with] poor short term memory [and] does not even realize she is picking. Has been tx'd [treated] for infection [and] antibiotics." * 8/19/08 - NN "Chronic skin picking causing injury to self. MD	F 323		

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F 323	Continued From page 31 [Physician] started Risperdal, has referred to [surgeon] for fiberglass casting. * 8/20/08 - NN "Noted scabbed areas on fingers [and] a finger nail that has been picked back a long way - none are new." * 8/25/08 - NN "[Resident #9] was caught today picking [at] her fingers [and] she was startled. She said she was picking scabs off to make it heal faster. Explained to her it would not help it heal faster [and] she is [at] risk for infection. She said she can't seem to leave a drsg [dressing] on it eigher (sic)." On 8/25/08, at 1:55 p.m., the resident's left third finger was observed with small open areas from the nail to the first knuckle. At 3:00 p.m., the resident was observed engaged in a group activity in the facility's activity room. Open areas with blood on the residents left third finger were visible. On 8/26/08, at 6:30 a.m., the resident was observed seated in a chair by a window of the main dining room. The resident was observed again in the same location picking the skin of her left third finger. No staff were present in the dining room during either observation. On 8/26/08, at 7:02 a.m., the resident was interviewed. When asked why the finger splint was not on her hand, Resident #9 responded that she did not remember ever having a finger splint, raised her left hand to display the third digit and said, "I know I have a sore finger." The skin on the finger was dry and cracked with several open areas, and the fingernail was torn off horizontally	F 323		

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F 323	Continued From page 32	F 323		

halfway down its length, exposing a dry and cracked nail bed.

On 8/26/08, at 11:40 a.m., Resident #9 was observed seated in her usual chair by a window of the main dining room. The resident was picking at the skin of her left third finger. No other staff or residents were in the dining room at the time of the observation.

On 8/27/08, at 9:03 a.m., the facility's DON, MDS coordinator, and corporate consultant were interviewed and asked about the facility's attempt to address the resident's chronic skin picking through medications used to treat psychiatric conditions other than Obsessive Compulsive Disorder (OCD). The MDS coordinator stated, "He never gave us a diagnosis for that, he just gave us the neurodermatitis." The three staff members were then asked about the psychiatric follow-up for Resident #9 from the local service provider and the time lapse between the neurodermatitis diagnosis on 6/26/08 and the 7/31/08 order for psychiatric follow-up. The DON responded that the local psychiatric care facility only conducted follow-up evaluations monthly, would not initiate a follow-up until a psychiatric diagnosis had been rendered by Resident #9's physician, and the psychiatric follow-up must be consented to by the resident's family.

On 8/27/08, at 12:55 p.m., the DON, MDS coordinator, and corporate consultant were again interviewed and asked to provide documentation regarding the resident's skin picking behaviors prior to the partial amputation of the right middle finger. The corporate consultant stated the partial amputation due to osteomyelitis may have been the result of an injury that the resident's family

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F 323	Continued From page 33 related had occurred prior to the resident's admission to the facility. The facility could not, however, provide documentation of the injury as related by the family. The DON stated, "We knew she had been picking at it, but we didn't know there was anything underneath," and the MDS coordinator stated, "It [amputation] was a shock to us." The three staff members were then asked what non-pharmacological interventions the facility had attempted to help prevent Resident #9 from causing self-injury by picking at the skin on her fingers. The corporate consultant stated the resident participated in most group activities and had engaged in individual activities such as towel and washcloth folding and putting together photograph albums. The three staff members provided no documentation of these individual activities and stated that no type of hand restraint had been attempted because Resident #9 was capable of removing each of the protective wraps the facility had previously attempted. The facility had carefully documented Resident #9's chronic skin picking and its resulting injury to self and infection, but failed to attempt or implement closer supervision and monitoring to prevent her from continuing to injure herself. 2. Resident #4 was admitted to the facility on 2/27/08 with diagnoses including stroke with right hemiparesis, dysphagia, and dementia. Resident #4's initial MDS assessment, dated 3/11/08, documented the resident had experienced falls within the past 30 days. A Post Event Assessment form, dated 6/15/08, documented, "Res[ident] found on floor on mat,	F 323		

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F 323	Continued From page 34 laying face down...it appears res rolled off of low bed onto soft mat. Res alarm sounded and alerted staff. No injury. Res has unsafe and impulsive behaviors R/T [related to] CVA [cerebral vascular accident]." A second Post Event Assessment form, dated 7/26/08, documented, "Alarm sounding, found res on floor next to bed on floor mat. No injuries noted...Res does try to get up but due to Rt [right] hemiparesis he is unable. He has been in a low bed with mat at bedside since March '08 d/t [due to] this behavior." Resident #4's care plan, dated 3/17/08 for the problem of "Falls/Safety issues", listed the following interventions: "Bed in low position", "Matt on both sids (sic) of bed", "Tether alarm in bed", "Freq[uent] checks on res", "Alarms to bed and W/C [wheelchair]", "Falling Star." The resident was observed asleep in bed on 8/26/08 at 6:40 AM. At 7:00 AM, a nurse entered the room and moved the fall mat away from the bedside in order to administer medications. The nurse did not move the mat back into place once she had finished giving the medications and left the room. The resident was observed, still asleep in bed, from 8:00 AM through 9:00 AM with the mat still moved away from the bedside. At 9:10 AM, a CNA entered the room and assisted the resident with getting out of bed and morning cares. The Administrator and DON were informed on	F 323		

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F 323	Continued From page 35 8/26/08 at 2:30 PM of the observations of the fall mat. On 8/27/08 at 8:20 AM, the DON informed the surveyor that the wife may have moved the fall mat as she often did when visiting. The surveyor reiterated the observation of the nurse moving the fall mat while administering morning medications. This is a repeat citation from the 6/15/07 recertification survey.	F 323		
F 367 SS=E	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure that residents received therapeutic diets as ordered by a physician. This was true for all residents receiving altered texture diets who received garnishes not appropriate for altered textures as well as 1 of 14 (#6) sampled residents who received thickened liquids without a physician order. This had the potential to cause harm for residents at increased risk of choking. The findings include: 1. During the lunch observation on 8/26/08 at 12:10 PM, Resident #6 was observed to receive a raw slice of spiced apple on her tray. The resident's diet order in the record and diet card on the tray, indicated the resident was to receive a mechanical soft/chopped diet. The apple slice was not of the consistency to be appropriate for this diet order and had the potential to cause the resident to choke on the food.	F 367	**F 367** **Resident Specific** The IDT reviewed resident #6's current diet needs, physician directives, and speech evaluation recommendations. A physicians order was received to downgrade resident diet to nectar thick liquid. Plan of care is updated. Dietary staff is educated regarding therapeutic diets, to include but not limited to, altered textured diet garnishes. **Other Residents** The IDT reviewed other resident diet orders versus tray cards for accuracy. No additional inconsistencies in diet orders we identified. **Facility Systems** Residents are assessed upon admission, with changes in condition and at least quarterly for therapeutic diets. A plan of care is developed and modified as indicated. Residents receiving speech therapy may have trials of various food textures. The dietary manager places a maximum 3-day	

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F 367	Continued From page 36 According to the Idaho Diet Manuel, Edition 9, foods to avoid on mechanical soft and puree diet textures include, "All raw fruit except for soft fruits listed in Allowed list (such as bananas, ripe melon, peaches, and pears with skin removed); fruit with tough membranes such as oranges and grapefruit." Tray line was observed on 8/27/08 at 11:30 AM. The garnish for the meal was a round slice of uncooked apple. This garnish was provided to regular, mechanical soft/chopped, and mechanical ground texture trays. The puree texture trays did not receive any garnish. Out of 78 total trays, 25 did not receive a garnish appropriate for altered textures. The Dietary Manager (DM) was present during tray line on 8/27/08. The surveyor asked the DM if different garnishes were provided for different diet textures. The DM stated she was not aware that garnishes were required to be the same texture as the diet order. On 8/27/08 at 1:00 PM, the DM informed the surveyor that all dietary personnel would be attending a mandatory in-service that afternoon regarding appropriate meal garnishes. 2. Resident #6 was admitted to the facility on 3/18/05 with diagnoses of urosepsis, confusion, congestive heart failure, history of anemia with B12 and iron deficiency, hypertension, hypothyroidism, osteoarthritis, and peptic ulcer disease. The resident's 7/28/08 quarterly MDS stated moderate impairment in cognitive skills for daily decision making was present, and the resident	F 367	automatic stop date on those trial diets. Tray cards are verified with physician orders to provide accuracy. Therapeutic garnishes are provided in accordance with texture requirement. **Monitor** RD and/or designee will review new residents placed on speech therapy to validate accurate diet orders. Tray cards will be verified against physician orders monthly. Any concerns will be address immediately. Dietary Manager and/or designee will monitor tray line twice weekly for therapeutic garnishes. The PI committee will discuss as indicated and may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** October 2, 2008	

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F 367	Continued From page 37 required supervision and set up assistance for eating. Resident #6's 3/18/08 Comprehensive Care Plan, updated 7/31/08, identified a problem with nutritional alteration related to weight loss and medical diagnoses. Listed approaches included "Diet per MD order: Mech [mechanical] soft diet with thin liquids." During observation on 8/25/08 at 1:20 pm and on 8/26/08 at 6:45 am, a glass of thickened water was observed on the resident's bedside table. Mealtime observation on 8/26/08 at 7:55 am and 11:35 am revealed thickened liquids were served with the resident's meals. During interview with a LN, on 8/26/8 at 7:40 a.m. she stated that the resident's liquids were to be "honey thick." During an interview with the dietician on 8/26/08 at 11:25 a.m. it was confirmed that facility did not have a doctor's order for the change to a diet including thickened liquids. It was reported the former speech therapist had initiated a trial of thickened liquids months previous, and the modified liquids had been continued, despite the fact no clinical indication or physician orders were in place	F 367		

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: David Scott, RN, Team Coordinator Lea Stoltz, QMRP Kari Davies, RD, LD, MPH Amanda Bain, RN Janice Ryan, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Nampa Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to dignity.	C 125	**C 125** Please refer to POC for F 241 RECEIVED SEP 23 2008 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: EXECUTIVE DIRECTOR

(X6) DATE: 091908

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C 291	Continued From page 1	C 291		
C 291	02.107,04 MODIFIED OR THERAPEUTIC DIETS 04. Modified or Therapeutic Diets. All diets, including general diets, shall be ordered by the attending physician. Diet orders shall be kept on file in the health care facility, and modified diets shall be reviewed routinely by the physician along with other treatment. This Rule is not met as evidenced by: Please refer to F367 as it relates to therapeutic diets.	C 291	**C 291** Please refer to POC for F 367	
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that all foods were stored following accepted food safety and sanitary practices. This had the potential to affect all residents in the 500 hall who ate food stored in the residents' nutrients refrigerator. During the General Observation of the facility on 8/27/08, at approximately 10:15 am, a partially filled beverage container was discovered in the residents' nutrients refrigerator. The beverage container had no label identifying the contents and was not dated. The facility dietician was present at the time of	C 325	**C 325** **Facility Systems** Beverages in refrigerator will be labeled for content and dated. **Monitor** Executive Director or designee will to random checks to refrigerators to ensure that all food items are labeled and dated. **Date of Compliance** October 2, 2008	

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C 325	Continued From page 2 the observation, and disposed of the container immediately.	C 325		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please refer to F253.	C 361	C 361 Please refer to POC for F 253	
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F281 as it relates to professional standards.	C 745	C 745 Please refer to POC for F 281	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plans.	C 782	C 782 Please refer to POC for F 280	
C 784	02.200,03,b	C 784		

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C 784	Continued From page 3 b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F246 as it relates to eating and toileting needs and assistance. Refer to F309 as it relates to pain management.	C 784	~~C748~~ C784 D.S. ~~C748~~ C784 D.S. Please refer to POC for F 309	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323.	C 790	C 790 Please refer to POC for F 323	